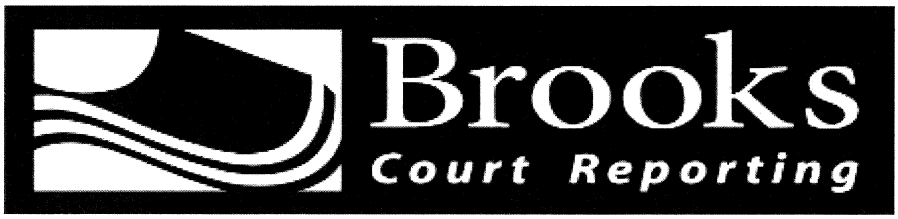
In Re: Resident Appeal of Joe Papin, MD

Transcript of Proceedings

July 18, 2017



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IN RE: RESIDENT APPEAL OF JOE PAPIN, M.D.

TRANSCRIPT OF PROCEEDINGS

Taken at University of Mississippi Medical Center, 2500 North State Street, Room R-227-8, Jackson, Mississippi, on Tuesday, July 18, 2017, beginning at 4:32 p.m.

REPORTED BY:

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Dr. Ayman Asfour
Dr. Demondes Haynes
Dr. Gustavo Luzardo
Dr. Ricky Clay
Dr. Lillian Joy Houston

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EXHIBITS

EXAMINATIONS

(Exhibit 1 marked for identification.)
(Exhibit 2 marked for identification.)
DR. BONDI: I'm Steve Bondi. I think everybody in here knows me or knows of me. I have been asked by the vice chancellor to chair this committee made up of graduate medical education committee members, of which we all are. And I'm going to have each committee member introduce themselves in turn in a moment, as well as the other individuals in the room.
A couple of preliminaries before we do that. First of all, this is?
COURT REPORTER: Shanna Cumberland.
DR. BONDI: Who is a reporter, a court reporter, who is transcribing this conversation, this hearing, so that we have everything on the record for future evaluation.
MR. DILLARD: Can you hear, Joe?
DR. PAPIN: Yes.
DR. BONDI: We just had a little cross talk. Sorry about that.
MR. DILLARD: If you could mute your phone, Joe, until the time is needed for you to un-mute it, I'd appreciate it.
DR. PAPIN: Sure.

DR. BONDI: Most of the people in this room are not used to working with a court reporter, and we, in medicine, tend to talk a lot and talk over each other, so I would ask everyone to be cognizant of that fact and pause and let -- let the court reporter know who you are when you're -- when you're speaking. So that's kind of the first point.

The second point is: This hearing is scheduled for an hour-and-a-half. I don't know how long it's going to take. We're going to make sure that we get it taken care of. We're going to be efficient, but we're going to make sure that everything that needs to get heard gets heard.

If it looks like we're going over an hour, we'll take a break. If somebody needs a break before then, please let me know and we'll -- we'll take a break.

Why don't we have everyone introduce themselves, and then I'm going to talk a little bit about the ground rules and how we're going to proceed today.

Once again, I'm Steven Bondi. I'm the chair of -- chair of this committee. I'm also a pediatric ICU physician.

DR. HOUSTON: Joy Houston, program

director for psychiatry.

DR. CLAY: Ricky Clay, program director of plastic surgery.

DR. LUZARDO: Gustavo Luzardo, program director for neurosurgery.

DR. WILLIAMS: Nilda Williams, senior radiology resident.

DR. HAYNES: Demondes Haynes, program director for pulmonary and critical care.

DR. ASFOUR: Ayman Asfour, A-Y-M-A-N, A-S-F-O-U-R, program director for pathology.

MR. DILLARD: Joel Dillard, counselor for Dr. Papin.

MR. WHITFIELD: Tommy Whitfield, outside counsel for University Medical Center.

MR. RAY: I'm Mark Ray, associate general counsel, Office of General Counsel, University Medical Center.

DR. EARL: Truman Marc Earl; I'm the program director for general surgery.

DR. BARR: Rick Barr, I'm the senior associate dean for graduate medical education and designated official of UMC.

MS. AINSWRORTH: I'm Bryce Ainsworth; I'm the senior administrator in graduate medical

education.

MS. BARNETT: I'm Tammy Barnett; I'm a paralegal with the office of general counsel.

MR. DILLARD: And Joe, could you announce yourself on the phone.

DR. PAPIN: Yeah, Joe Papin.

DR. BONDI: Okay. Thank you.

There are some other individuals that we will likely hear from later this afternoon. They are specific witnesses to some of the conduct that is going to be presented later. The reason they aren't in the witness is -- or they aren't present is because they've been sequestered. Dr. Earl as the program director is going to be here during the entire presentation and as is Dr. Barr as the institutional representative for GME.

Any questions about that so far?

Okay. So the purpose of this hearing is to evaluate the appropriateness of the termination of Dr. Papin, both the facts and the process, and we're going to talk about -- we're going to go through both of those.

The specific procedure today is going to be that Dr. Earl is going to make his presentation first, then we'll give Dr. Papin an opportunity to

address the committee but not Dr. Earl. We're going to follow that by any witnesses that Dr. Earl thinks is appropriate. Dr. Papin will also have the opportunity to specifically address issues that are brought up at that time to the committee.

Once that's concluded, Dr. Papin will have an opportunity to address -- address the committee and then Dr. Earl will have an opportunity thereafter.

At the end, after everyone's had their opportunity to be heard, the committee is going to meet and -- and discuss the case. We are not going to come up with a decision today that is going to be published to the group; it may be tomorrow. But I -- we don't want to feel that time pressure that -- that we're sitting here to publish a decision today. I just wanted to manage the expectations.

Furthermore, this is not a lawyer process. This is an informal graduate medical education process, so I don't expect the counselors for either side to be part of the process directly. Indirectly, if people need advice, that's appropriate. If we need to take a timeout for that, that will be appropriate as well.

Any questions about that going forward?

MR. DILLARD: I -- I guess I just want to -- this is Joel Dillard.

I just wanted to clarify that the attorneys will not be objecting?

DR. BONDI: Correct.

MR. DILLARD: And won't be asking questions?

DR. BONDI: Correct.

MR. DILLARD: Won't be calling witnesses?

DR. BONDI: The attorneys won't be doing that, but their -- but the individuals, Dr. Earl and Dr. Papin, can certainly do that as necessary.

MR. DILLARD: So the -- the expectation will be that Dr. Papin would call witnesses and question them himself?

DR. BONDI: Yes, or have them speak their narrative, yes.

MR. DILLARD: And is the expectation that Dr. Papin would ask questions of Dr. Earl's witnesses?

DR. BONDI: He can ask -- he can present his questions to the -- to -- he can make his point to the panel, to the committee.

MR. DILLARD: Okay.

DR. BONDI: He is not going to be cross-examining the witnesses, which I think is what you're really getting at.

MR. DILLARD: Right. Thank you.

DR. BONDI: Okay. The other thing is, I would encourage the panel members to actively ask questions, and I think we're going -- we're going to be doing that. We need to represent not just the institution but also the house staff and Dr. Papin. So our obligation is to -- is to try to elicit all the facts that we can, so you should be hearing from us, as well.

Okay. All right. Any further questions or comments before we start?

DR. WILLIAMS: Nilda Williams. When a resident is fired from a program, are they able to join another program potentially?

DR. BONDI: Potentially, yes, although that's really beyond the scope of what we're talking about today. I think it does go to the impact on the decision that we have to make, the solemn decision that we have to make. Yes.

DR. ASFOUR: I have a question. Was the resident offered the potential to resign?

DR. BONDI: We're going to talk -- that's

something that Dr. Earl, when he goes through, you can certainly ask that question after he has an opportunity to present.

Go ahead.

DR. EARL: Okay. So again, I'm Truman or Marc Earl. If I call myself "Marc," that's my middle name, so sorry.

But Dr. Bondi asked me to give a general timeline of events to start with and then go into a more detailed narrative that lead to Dr. Papin's termination.

The -- he began his residency as a categorical surgical intern last July, so July 1st, 2016. Within the first month, we had issues that were unique, but I assumed they may just be personality conflicts and we counseled him. But then, basically, it became a pattern of difficult interprofessional relationships, difficult relationships with other residents that led to multiple counseling sessions throughout -- or meetings with me, as well as other faculty members over the next four months, with guidelines given of things that needed to improve, things that just can't be done. And that, ultimately, then led to a formal meeting with me on December the 20th, where

we documented things that needed to be improved. They were never academic issues; they were professional issues unrelated to the ability to -- or excuse me -- unrelated to the medical knowledge of surgery. They were related to professionalism.

December the 20th, we had a meeting and discussed things that needed to improve and that I was -- that he was under scrutiny.

After we go through the holidays and multiple reports coming from multiple sources came back to me that we had issues with truthfulness, some of which certainly created the potential for patient harm and possibly contributed to actual patient harm. And so I counseled Dr. Papin and said, "These are things that cannot happen because patients, individuals could be hurt by this." And we discussed that.

After we talked, I went and met with Dr. Barr in the GME office, who asked me, essentially, "Is this an academic issue or is this an employment or professional issue." It very much was an employment, professional issue of telling the truth, being on time, doing the things we've said we've done.

He, then, recommended or decided, and

which I agreed with completely, that this was an employment issue and needed to be referred to HR. We referred it to human resources, that then after -- and we were also advised, because of concerns of patient safety, that he was to be placed immediately on administrative leave, which he was.

HR did their investigation and ultimately came back to us in February -- I don't remember the exact day; I believe it was February the 11th or something like that -- that Dr. Papin should be terminated for cause. And I believe it was based on breach of his employment contract. And therefore, he was -- he was terminated.

Now, so that's sort of the timeline of events. It began in July. The issues continued. And I think these are -- these were unique issues. These were not -- I was not dealing with a sampling of these various different issues with other trainees and 33 residents. These were completely unique to Dr. Papin. Which, again -- and it repeated, so it caused a lot of concern on my part.

The specifics of the events that lead to all of this were -- began in the cardiovascular ICU. And as -- as all you guys know, in surgery, we have a lot of touches all over the hospital, ICUs, ERs,

children's hospital, adult hospital, and so there were concerns across multiple care environments.

It began in the cardiovascular ICU where there were multiple reports from nurse practitioners, nurses, as well as e-mails to me from cardiovascular ICU faculty about difficult interprofessional relationships, complaints from nurse practitioners about not doing tasks that we were asked to do, that these were beneath the physician. These were documented in the evaluations from that rotation.

You know, as program director, I thought maybe this is just a personality conflict. And you know, there was one run-in with a specific nurse practitioner that almost turned violent, and I believed then and I believe now, even, that it was both of them contributing to that.

But I talked to Dr. Papin and said, you know, "Listen, we've got to -- you've got to walk away from these kinds of situations. Let's just make sure this doesn't -- this pattern of behavior doesn't continue."

Goes to the next rotation, and I have similar complaints from faculty, nurse practitioners, as well as nurses on that floor. I

know that the faculty on that service spoke with him. The same pattern of evaluations continued: Not doing assigned tasks, be it assigned by a nurse practitioner or a clinic nurse or anything like that. Sort of our ethos in surgery is that, you know, especially as an intern, "You're new to the team; you do whatever you're told; you do whatever you're asked." And that was not happening.

Again, the pattern continued such that then I said, "Okay. This is unique. I've -- I've actually never encountered this, continuing across multiple rotations and multiple environments within the hospital. He's going to come rotate on my service."

So he rotated on my service in October. And from multiple sources, again, nurse practitioners, nurses on our transplant floor, OR nurses. And these were not just random OR nurses that may show up from time to time in our operating room; these are folks that I work with all the time. Same pattern of behavior: Not willing to do tasks, not willing to help, some concerns of untruthfulness.

Again, we go to the next rotation, and I have the same issues. Met with him again, and I

believe I met with him at some point during that time. I'm not certain. Met with him again in November, when he was on the general surgery service. I had complaints from faculty about not showing up on time, not being where he was supposed to be, walking out of the operating room.

I met with him November. I was scrubbing into a case outside of OR 16. Met with him, laid it out there, "This has to change. This is now very clearly a you problem because I've got 32 other trainees that this is not a problem for, and -- but this has to improve."

Go to the rotation in December, and I start hearing reports of where -- not rounding on patients we say we've rounded on, not giving information that is correct. I've looked at something I haven't.

And so at that point, we met on December the 20th, and I met with Dr. Papin -- our residency program coordinator was there, as well -- and said, "This -- we are -- all these things have to change. These professionalism issues have to change or the consequences will be dire."

We were going into the holiday period, which is a tough time in our residency because half

our residents get one-half -- you know, get the Christmas holiday off, the other half get the New Year holiday off, and so it's the same amount of work for half the people.

Made it very clear that I would be -- we were -- you know, I was concerned that I would be seeking feedback. I did not seek feedback until after all this happened. And many of the folks that will talk today are the folks that were with him during this time.

The untruthfulness became worse, it appeared, and were -- was -- although I never witnessed any of it personally, the sources that were coming back to me were first-hand knowledge and it was really from so many sources.

At that point, I -- and there was concern that some un-- that some of the untruthfulness led to potential patient harm, or at least failure of one safety mechanism. The issue specifically was a patient who wound up with a Stage 4 decubitus ulcer, where the chief resident asked him on two occasions if he had examined the patient's backside on two subsequent Mondays, and the answer that was repeated was what was in the wound care notes from the week prior.

Realizing that, you know, it's not just the physician's responsibility, you know, but certainly that's one safety mechanism of ensuring that these types of things are caught early and treated. That mechanism failed and certainly that created the potential for -- or the safety mechanism that that chief resident was trying to put in place to examine that patient's backside and try to prevent things like this from happening failed.

At that point, I did not feel like this was an issue that I could educate somebody out of, that the telling the truth, showing up on -- telling the truth, being honest, making sure that all of your actions are centered on that patient's best possible outcome and not making your -- that are not self-centered, that this was not a -- this was not a "you need to know more about surgery issue; you need to know more about how medicine is practiced." This was very clearly an issue where we could not trust him to take care of patients safety -- safely.

I would, as a program director, never feel comfortable about him being alone or trust anything that he said about patient care. And to me, that was -- there was never any way that I was going to be able to advance him, much less put my name on the

bottom of his surgical training saying that he was going to be a safe, competent surgeon. Not based, again, on his medical knowledge, but solely based on truthfulness.

So at that point, I met with him, I told him about all of this. We discussed that he would have 60 days to make this better. I did that because I thought I had to. And I went -- right after that, went to the GME office and met with Dr. Barr. We went over all the facts of the case. Dr. Barr very explicitly asked me, "Is there anything he can do to where you'll think he will be able to come back and where you can trust him," and I said, "At the point, no."

We have had so much scrutiny on him, and as this scrutiny got worse, the evidence of untruthfulness got worse, which, to me, spelled out that I was very concerned that we were more -- that he was more concerned with how he appeared to be performing rather than how he was actually performing.

Dr. Barr said this is not an academic issue; this is an employee issue that applies to all employees throughout the entire University, not just GME. And so -- that we needed to refer to this to

HR. And that he felt, and I wholly agreed, that this was grounds for -- that this was not -- he was not safe for patient care and that we needed to get him out of the hospital as soon as we could.

And HR looked over the case, talked with both of us, with Dr. Barr and myself, and agreed. And so we put him on administrative leave, had several meetings -- or HR did their normal process for this kind of thing, and based on their findings, recommended termination for cause immediately.

DR. LUZARDO: Can we ask questions?

DR. BONDI: Please.

DR. EARL: Please.

DR. LUZARDO: This is Dr. Luzardo from neurosurgery.

Where does he come from? What is his school, medical school?

DR. EARL: University of Michigan.

DR. LUZARDO: Okay. Do we have any background?

DR. EARL: So actually -- so I mean, for me, I was actually very excited about Joe coming. He actually worked in a lab -- if I remember correctly, I know Joe -- Joe failed a match his first year, and I believe it was in urology, which

is not uncommon. It's not an easy thing to match into. It's relatively competitive.

But work -- spent a year working in a lab in a -- in a -- with a transplant surgeon that I actually know pretty well and came highly recommended. But no clinical background. That was the only background that I -- that I had.

DR. LUZARDO: Has he -- does he have any history, to your knowledge, of mental illness?

I mean, let me clarify this. What is described here is a deranged individual that cannot adapt to reality. This is not a behavior of somebody who just tried to hide some deficiencies.

So does he have any history of mental illness?

DR. EARL: Not to my knowledge.

DR. LUZARDO: Do we have -- or has he, in any, submitted to a drug test?

DR. EARL: Yes. So as part of our -- as part of our -- the GME process, when I went to Dr. Barr, that was -- and said, you know, "We have a serious problem," the first thing that was done was the fitness for duty evaluation. So drug testing was done. And he was put on administrative -- he was immediately put on administrative leave.

DR. BONDI: Okay. This is Steve Bondi.

What opportunities were there where you interacted with Dr. Papin where there was formal written feedback either by you or other attendings?

DR. EARL: Certainly, on December the 20th, we went over all of his written evaluations. Where there was written provided feedback to him, that -- that was the only time where I actually handed him a piece of paper. The residents have -- obviously, have access to all of their evaluations at any point in time.

DR. BONDI: Could you elaborate on that a little bit? Because not everybody probably knows how -- I know how that process works, but --

DR. EARL: Sure. And I have all of his evaluations here.

The faculty, when they evaluate a resident, the -- they fill out questions regarding all issues surrounding medical practice, medical knowledge, professionalism, things like that, and it's usually rated on a Likert scale. We use a Likert scale, 1 to 5.

But there's also the opportunity to put in comments. That's done on an online system, which the residents have 24/7 access to. And there are

also peer-to-peer evaluations that are done, so residents evaluate each other.

DR. HOUSTON: I think I saw, too, that you had also done his semi-annual evaluation by that point, right? I think that was dated for November.

DR. EARL: That was in November, yes.

DR. HOUSTON: So that's formal, written feedback, as well, right?

DR. EARL: That's written -- written, formal feedback, as well, yes.

DR. BONDI: Do you have that -- I don't know if everybody has read through that. Do you have that available with you today?

DR. EARL: I don't know that I -- I'll have to -- let me see.

DR. CLAY: Are you referring to his milestones?

I'm sorry; Ricky Clay.

DR. EARL: Well, his semi-annual review that, you know, we obviously have to do.

DR. BONDI: Careful, guys, one at a time.

DR. EARL: So here is a copy of the -- the discussion that we outlined. That's page -- I'm sorry.

DR. BONDI: This is Dr. Bondi.

We've just got to make sure that we're -- we know what's being referred to.

DR. EARL: Yes.

DR. BONDI: So this is an e-mail from -- from Dr. Earl to Molly Brasfield who's one of our --

DR. EARL: It was actually the e-mail that was sent to -- I'm sorry -- Marc Earl -- to Renee Green, is the original --

DR. BONDI: Right.

MR. DILLARD: Could I -- could I make a point of clarification?

DR. BONDI: Please do.

MR. DILLARD: Maybe what might make sense is if the court reporter has a copy of the documents which have this Bates stamp on it, Papin 01 through this, you refer to them by the Bates stamped number.

DR. BONDI: I'd be happy to do that.

MR. DILLARD: It will make the record clear forever and forever.

DR. BONDI: Okay. Thank you. I appreciate that feedback.

So we're looking at what's been labeled as Papin 003, and that's the e-mail from Dr. Earl to Renee Green, clarifying what I said before.

MR. WHITFIELD: Dr. Bondi, for

clarification -- this is for the record -- that's part of Exhibit Number 2.

DR. BONDI: Okay.

MR. WHITFIELD: All the Bates documents are Exhibit 2.

DR. BONDI: Okay.

MR. WHITFIELD: And the notice of the hearing is Exhibit 1.

DR. BONDI: Okay.

MR. WHITFIELD: So for record clarification, that's where the documents are located.

DR. BONDI: Okay. Thank you.

DR. EARL: The other -- I don't -- I don't know -- I don't know that I have a copy of his actual semi-annual review, but I do have copies of his milestones, which he received -- out of 16 milestones in general surgery, he received seven critical deficiencies.

Our clinical competency committee -- so for those not in the GME world, the clinical competency committee is a ACGME mandated committee of at least three faculty member -- faculty members that then evaluate resident performance based on multiple sources, not just evaluations and hearsay,

but also other -- and personal experience. But all -- all information we have regarding -- or evaluating resident performance, and then they make a determination of where that resident stands in the progression towards competency as a general surgeon.

I am not a voting member of that committee. I -- I am not even part of that. I use other faculty to do that. Program directors can be a part of it, but I -- in our program, I am not.

So this was done by other faculty members. He received 7 of 16 critical deficiencies, which, again, is a tremendous outlier.

DR. LUZARDO: Let me ask two questions. The first one is: What is the purpose of the lawsuit? What does he expect at the end of this lawsuit? What is he in search of?

It seems to me that this is beyond a point of no return.

DR. BONDI: So we're not talking -- that's not what we're talking about. What we're talking today here, is he has appealed the determination of the department of surgery and the graduate -- graduate medical education department. And we -- our job is to review that decision and see whether he was both given appropriate process and whether

the facts support that determination.

DR. LUZARDO: Was he given the opportunity to resign by HR, to anybody's knowledge?

DR. EARL: No. We -- he was terminated. And there was -- he was -- the determination was made to terminate with cause, and so that was --

DR. LUZARDO: Yeah. But he could have resigned at any time before?

DR. EARL: He could have resigned.

DR. LUZARDO: He elected not to?

DR. BONDI: I'd like to ask a follow-up question.

So the summative evaluations, did anyone go over those with Dr. Papin?

DR. EARL: Yes, yes.

DR. BONDI: And who was that?

DR. EARL: Me.

DR. BONDI: Okay. And do you remember about when that was?

DR. EARL: That was during his semi-annual review in November.

DR. BONDI: In November. Okay.

DR. WILLIAMS: Nilda Williams.

In reading his statement, it seemed like -- so if November was when he met with

(unintelligible) and then January was when he was on administrative leave, it's kind of -- that's time -- but you're not a lot of time and then just from what he read, what he had said or whatever, is that he was unaware of a few of the complaints. I don't know. He -- I mean, a lot -- he said many times, "It was the first time I've heard of anything like that."

DR. EARL: That's -- and throughout all -- so having met with him multiple times, literally almost monthly throughout this, that was a constant question. "I need feedback. Nobody is telling me anything." I don't have any other residents I'm meeting with monthly for interprofessional, professional issues, not one. And so he was always aware of what I was hearing and what I was being told much more so than any other trainee.

DR. HOUSTON: Joy Houston.

Just a follow-up on Dr. Luzardo's questions. Since we hear that pretty much every time it was treated as though it was new information, was there any suspicion of cognitive difficulty?

DR. EARL: No. I mean, I -- well, I had no suspicion. I actually think Joe is very, very

intelligent, and so I never had a concern of -- like I said, of medical knowledge, of cognitive problems. I mean, that never really -- I mean, obviously, substance abuse, things like that were concerning, because the pattern of behavior was so different than standard resident and so unique. But I never had concern of any sort of cognitive problem.

DR. LUZARDO: Since a recommendation was from an acquaintance of yours at the University of Michigan, then I don't quite see -- did you follow up with that person? Have you rediscovered anything since all this came to light?

DR. EARL: I have not.

DR. BONDI: I know you said you discussed -- I'm sorry. Steve Bondi.

I know you discussed the specifics with Dr. Papin on several occasions, which you told us. Was there any memorialization of those specific events? Meaning did you, like, write down "I'm talking to you about this, this and this" or are you memorializing on your own?

DR. EARL: Certainly, there was a review of all of his evaluations at the November semi-annual review, and then, obviously, the e-mail. I think it's Number 3.

DR. BONDI: So let's just make sure we're referring to -- we're all looking at the same document.

Is that the same one we're talking about?

DR. EARL: Yes.

DR. BONDI: This one here?

DR. EARL: Yes, December 20th.

DR. BONDI: So Dr. Earl is referring to that same Exhibit 2, Bates Number 3 document.

One of things you -- you mentioned was that there were multiple episodes of -- of untruthfulness, and you gave quite a bit of detail on the one at the end about the -- about the wound care.

DR. EARL: There were several others.

DR. BONDI: Do you -- do you recall any of the specifics about the other episodes?

DR. EARL: I do. And I -- I had two senior residents: One was a senior resident complaining or telling me that he had signed out a patient that was going from ER to ICU when there was no evidence that that ever happened and the ICU didn't know the patient was coming. Obviously, that's concerning.

There was another issue of a wound that

was claimed to have been washed out. Two chief residents -- senior residents -- sorry -- their senior residents -- there was knowledge of the bedside nurse -- and this was somebody in the ICU, a trauma patient that that had ever happened. And the senior resident asked him if it had been done; "yes." The senior resident went there; the bandage was still the old bandage. The senior resident had to do it.

There was, then, unsolicited feedback from a medical student that was on the service with him, and I believe -- I don't know if I need to refer to the actual document, but that document is Exhibit 2, Bates Number 8, from William Crews, who is a -- was a third-year medical student on the trauma service, stating that he would not come in -- he would come in typically after, when the other interns would come in. The students would see all the patients. He would not have seen any and report to the chief resident that he had seen them. That occurred on multiple occasions. And that -- the chief resident suspected that, the medical student corroborated it.

I'm trying to think if there's more. There was -- let me look through some of these e-mails.

One of the issues we had was leaving campus, as well, while on call to go run or exercise. I mean, obviously, during the day and on first call, that's just not something we do.

There was an issue -- and again -- I mean, another issue that just sort of, to, me spoke to professionalism and really went against what I, as the program director in surgery, think as sort of at the ethos of surgery -- really, of medicine, frankly.

But there was a patient on the service that he was on that coded at or literally minutes on the floor after sign-out. Patient was not signed out as sick or anything. It may not have been; I don't know. But then, when the oncoming intern texted him and asked him, "Come back, help me" -- and this was minutes after 6:00 o'clock at which sign-out occurs. And I've seen the text message that were sent back and forth.

It was just he reacted with -- very inappropriately, I thought, very angry at the prospect of, "You need to come back. We need help. I don't know what's going on with this patient." And one of the senior residents witnessed all that. This is on -- again, on his service, this is his

patient.

That just, to me, was very, very much not congruent with the type of surgeon that I want to train. If requested, you will always come back.

So those are -- again, this is the same Exhibit A or whatever, 2, Pages 27 and 28. If anybody wants to read those, those are the text messages that were sent to his co-intern. And the timing of those is 6:16.

DR. BONDI: Are there any further questions from the committee members for Dr. Earl at this time?

So Dr. Papin -- I'm sorry -- it's Papin. I apologize. This is Steve Bondi, the -- the chair. We're going to give you a specific opportunity to present your side later, but if you would like to direct specific comments towards what Dr. Earl has said at this time, you're welcome to do that. I would appreciate if you direct those to the committee. And we may, after hearing what you have to say, ask some question of Dr. Earl.

So you can use this time to do that now, but you'll also get an opportunity to certainly give your -- give your uninterrupted side of -- of this.

MR. DILLARD: Can I have two minutes?

DR. BONDI: Of course. We'll take a brief break.

(Off the record.)

DR. BONDI: All right. So Dr. Papin, what would you like to add at this point to the committee?

DR. PAPIN: Sure. You know, I'd like to add, first and foremost, that I think in the six months I was there, I was never really given an opportunity to show any sort of improvement. I wasn't given any sort of feedback, based on the small amount of feedback that I was given to improve in any way.

And then I -- I think the issue that -- that Dr. Earl brought up, I think you can break them down into professionalism and then issues of honesty and then a few other things that he brought up, so I'll go with professionalism first.

Even in my evaluation -- and I mean, I'm quoting this -- but I'm polite, I get along with everyone, and then there's others that don't say that. So at the very least, that's me.

Second of all, going on to the same point of professionalism, I asked Dr. Earl, and he was telling me, you know, I'm getting reports from

nurses, you know, but he wouldn't give me anything specific. And I think he said that, and he kind of contradicted himself, that he gave me absolutely no specific instances when something was happening, which I would have found incredibly helpful. Because obviously there's a disconnect between, you know, these reports that he's supposedly being given and anything that I'm seeing or experiencing. So you know, the -- it would be really helpful to see, okay, this is something specific, now, okay, that's when I was unprofessional in some way, and now I can take action.

And then, on the points of honesty, he addressed four of those. There was the decubitus ulcer, the issue with the ICU, and another issue that was within the ICU about a wound washout and then the fact that I, at some point, never saw patients.

So when it came to the decubitus ulcer, again, he never mentioned that specifically to me, ever. What he did tell me in that January 10th meeting is that I -- I had said that I performed a physical exam, and I, in fact, didn't and it led to direct patient harm. And that was all he would tell me. In fact, on that -- on that time and other

times when I would ask him specific, he would get angry, irate and tell me, "Joe, you always do this." This is how feedback is in surgery. A sigh in the operating room for an attending no longer listening to your presentation, that's your feedback. You know, the big -- and I'm still paraphrasing what he said. There's a big movement in surgery to get more feedback. I don't believe in it. I don't think so. I mean, you know most of the feedback that you get is nonverbal. So -- so that was that was what I got.

I -- once I found out about this decubitus ulcer issue in the HR meeting, I offered evidence from my phone that I, in fact, had communicated all of this information, that it had been documented that this patient had had a decubitus ulcer before I even began and that I wasn't the only resident or nurse practitioner that -- to see him, not that -- I'm not a nurse practitioner, but there were nurse practitioners that rotated on and off the service, two of them that alternated. There was two other interns on the service at the time. There was a chief resident, Meghan Mahoney. You know, there were several other people, and it was documented before I even got on the service that this person

had a decubitus ulcer and had been being followed by the decubitus ulcer team. I went and saw this patient, I saw the wound. There was a scab covering it. And I communicated that to Meghan Mahoney that it didn't look that bad. Well, I didn't realize that if you peel off the scab, you know, obviously, it looks much worse. I wasn't able to see it again. But I guess it looked much worse when she peeled that scab off.

But when you look at a textbook, you know, the stages of decubitus ulcer, they don't show a scab. So it wasn't that I wasn't looking at these wounds. It wasn't that I was lying about having seen these wounds. There was just a gap in medical knowledge.

The wound washout, that was brought up to me. I did the wound washout. Moreover, when I did the wound washout, there was a ophthalmology resident in the room conducting -- I believe he was suturing this patient's eyebrows at the head of the bed while I was prepping and I also started doing the washout myself. So I don't have access to medical records anymore, but it would be pretty easy to see which ophthalmological resident wrote a note, and we can ask him. I'm sure he would remember me.

I grabbed a suture for him, helped him out. We talked in the room.

So you know -- and I communicated that to Meghan Mahoney, and nobody said anything to me until days afterwards, until Meghan mentioned something to me and asked me about this. And I told her the exact same thing.

And then the issue of never having seen patients. (Unintelligible) I arrived, I'd sign out. You've got to sign out with interns, the other intern. I went back up, saw patients, and then we would round table rounds with the senior resident, Meghan Mahoney about 6:45 most days.

So I don't really know the genesis of that story. Again, this is the first that I heard that this was occurring at all, was in the documents that were sent to my attorney, Joel Dillard. So you know, I really can't comment much more on that other than to say that that never happened.

And then there was another issue which I haven't brought up before, but going to -- Dr. Earl mentioned this. He mentioned this to me specifically as well.

Going out to run and go for exercise. You know, I've seen many others residents leave the

hospital during work hours to go and exercise. And I asked Meghan Mahoney on one specific instance if it would be okay, you know, if there was nothing going, if it would be okay if I just brought my pager with me and went for a run right around the campus. She said yes, and this is commemorated by a text. And she said yes. I did it; there was no issue.

Then you know, sometime later, the same situation happened, again. It was pretty -- I got all my work done at that point, and I texted her and she became irate, started cursing over the text message, you know, swearing.

And evidentially, she shared that with Dr. Earl, and Dr. Earl spoke to me about it. And what he didn't know was that she had let me go before. And he was surprised, actually, in the meeting when I told him, "Well, she had let me go before, and I was just asking." It's not like I did it without permission or even getting with them at all. I did it the one time with permission and that was it. And I offered to show him the text messages but he declined.

And that's kind of a pattern. I was never really able to give any sort of evidence to refute

or even know the circumstances under which most things occurred.

And then to go back to the issues of honesty, the ICU -- you know, these are -- this isn't unique. This is -- I mean, this would happen all of the time where a resident would say they had spoken to the ICU, and someone in the shuffle of the ICU wouldn't know that somebody was coming. But what I had done was I had put in the admission orders for the patient. I had put in the admission orders for this patient to go to the ICU. I communicated everything about this patient, status and everything, to the senior residents, and the note was in -- and I had spoken to the ICU. And evidentially after I had left, a conversation to which I wasn't privy, call and spoke to the ICU -- he said he was working an overnight shift, if I remember correctly, and I was done whenever I was done. He called me -- I was already called when he called me and asked me to confirm that I hadn't spoken to the ICU, and I said, "No, I have."

You know, but -- you know, that's -- that was what was occurring and that's not unique. That happened very frequently.

And then, there was some other issues,

too, that Dr. Earl brought up that he switched one of my rotations to be on his service, the transplant service, in October. At the completion of that rotation, I asked him how I had done. I solicited the feedback. I asked him, you know, how did I do in his service or something. He told me I did a great job. You know, no complaints whatsoever. And then a few months later, November, December-ish, he told me, "Well, once I spoke to the operating room nurses, actually some of this -- you know, it was communicated to me that" -- you know, whatever it is that was communicated to him, he didn't really expand much on it. But that I, in fact, hadn't done a good job. So that, to me, was odd.

And then just feedback overall, like I said, it seemed like Dr. Earl correctly characterized the fact that I would ask and not be given instances and facts. Not -- and denies -- and he would become irate that I would even ask for -- you know, when someone is telling you you're doing a poor job in some aspects of your job, what specifically it was. And I didn't do it in a manner to question it or you know, to attack it; I was doing it to genuinely improve. And he just didn't -- that wasn't what he described, I suppose.

And then there were a few other issues, you know, that just come up for the very first time. For example, walking out of the operating room. Dr. Earl mentioned that. That's new to me. Being late frequently, again, he had never, ever in any of our conversations, in person, written, in any form of communication mentioned that I had a problem with tardiness. This is all something that's came out after I was dismissed and in those communications that were sent to my attorney, Joel Dillard.

DR. BONDI: Did you have anything else to add -- this is Steve Bondi, again -- at this time? You're going to have another opportunity to -- after all of the witnesses have spoken, to speak to us again.

DR. PAPIN: No. That's it.

Thank you.

DR. BONDI: Okay. Do any of the committee members want to ask Dr. Earl any questions based on what we've heard?

DR. HOUSTON: Joy Houston.

So speaking of mixed reviews, I know that at least in psychiatry, it's actually kind of uncommon for a faculty to be all that explicit with negative comments.

DR. EARL: Yes.

DR. HOUSTON: Faculty tend to be kind of reluctant to give negative comments. Is that the case with surgery as well?

DR. EARL: Actually, it -- it's definitely the case with surgery. It's hard for us to get comments, typically, and negative comments are abnormal.

DR. HOUSTON: And so would you say that this is an abnormal number of negative comments for a single resident?

DR. EARL: Without a doubt.

And I actually ran the statistics on his evaluation numbers, because if you look, three is in the middle. But when look at it, you run the statistics and you compare it to the other interns, he's actually a standard deviation below the other interns. And these are evaluations from other residents. And a lot of -- and yes, so to answer your question, that's true.

DR. HOUSTON: Well, to follow up on the statistics: In that case, I would assume that similar to probably most of our programs, it's actually rather unusual for any faculty to give someone anything below a three?

DR. EARL: That would be correct. It's unusual. It does happen from time to time, but yes. That -- that is correct.

DR. LUZARDO: The University -- I would expect that they would have had that. But there is a timestamp with the use of the badge for people who is on call when they remove the car from the campus. And we don't have that all along during the six months he's here? That can be graphed very easily, the times he's on call, the times that -- you know, rounds starts at 7:00. If he started at -- you know, the timestamp to the entrance of the parking lot -- I think that, perhaps, not now -- I don't know if the University has it.

But it's a vitals -- we have that, actually, real issues with the staff over documentation of cases of being present for the case where you stamped your parking lot out. So that would be something to consider.

DR. BONDI: I have a question about the evaluation. This is Steve Bondi, again.

I know that I don't always submit my evaluations on time. I'm sure everybody on the panel here is scrupulous with their timing.

Do you -- and you may not know this. Do

you recall how timely the evaluations were in the system for -- for him?

DR. EARL: I do not. I know that most -- many of these evaluations were available in November.

DR. BONDI: Okay.

DR. EARL: But yes, there is, without a doubt, a lag between the information that I have to give back to the resident and real time, and I do not often have information as it is happening. So whenever we -- you know, if I -- unless I have a -- really, a dire issue where we have a severe patient safety issue that is actively happening and we need to pull somebody out instantly, that information can lag from days to weeks to months, actually.

DR. BONDI: And I have little doubt that you nag your faculty in general, that, "Hey, I need to get the evaluations done."

Did you ever do that specifically about him?

DR. EARL: No. I do it in general all the time, "Please, please do this." We have an automated system that generates e-mails asking faculty to return this, as we all know well, and specifically, I have to -- but no, I never

specifically ask faculty, "Please give me -- fill out your evaluations for Dr. Papin" specifically.

And these evaluations are actually -- I had redone them prior to the beginning of the year such that they are mapped to our milestones and not just the comments, but the questions, as well, and were done specifically so that I could get better feedback for the resident as -- as it relates to the general surgery ACGME milestones.

DR. CLAY: If I may interject -- Ricky Clay, plastic surgery -- to just point out, in the department of surgery, there is actually an RVU penalty for late evaluations. It costs us not to send our evaluations in on time.

DR. BONDI: I'm really glad we don't have that in the department of pediatrics. That's all I'm saying to Dr. Barr, who is the chair of department of pediatrics.

Does anybody else have any other questions about what we've heard for Dr. Earl at this point?

MR. ASFOUR: Ayman Asfour, pathology.

You have six months evaluation for this?

DR. EARL: Yes, I have all the evaluations that I received.

MR. ASFOUR: And you -- the CCC committee,

they came out with the decision this person is not fit to go to next stage?

DR. EARL: Well, they -- they -- they -- out of 16 general surgery milestones, we had seven critical deficiencies.

MR. ASFOUR: So he had seven documented in the CCC committee?

DR. EARL: Yes.

MR. ASFOUR: So it's not your word against his word?

DR. EARL: This is what the CCC committee came up with.

And I believe that I was even absent when they met from that meeting. I mean, a lot of times, I'll attend and just listen because I -- I like to hear the feedback. I -- I go sort of out of my way to be quiet, typically, in that committee, because I just want to listen. Because getting feedback about residents is actually a very hard thing to do from faculty members. It's not an easy thing to get, and that's a good place for me to get it. But I think it was absent, but I can't -- I can't say that for sure.

DR. BONDI: Doctor, who would you like to have us hear from next?

DR. EARL: The CCC committee. I explained that earlier.

MR. DILLARD: Are we still aiming to be done at 6:00?

DR. BONDI: Well, I don't think -- I mean, it's a quarter -- it's 25 'til 6:00. I don't think that is going to occur.

MR. DILLARD: Okay.

DR. EARL: The CCC committee, that's what we were -- the -- it's the clinical competency committee that is made up of three faculty members, that creates the milestone document that advises the program director about a resident's progression towards competency. And what -- and it is unique to each medical specialty.

DR. WILLIAMS: Nilda Williams.

That's just for a problem resident or it's done for each?

DR. EARL: It's done for every resident everywhere.

DR. WILLIAMS: Every six months?

DR. EARL: Every six months.

DR. WILLIAMS: And November was when this meeting happened?

DR. EARL: No. The CCC committee did his

milestones -- I would have to look back at the exact date that it was filled out.

DR. WILLIAMS: Can I ask Dr. Papin a question?

When is the first time that you saw an evaluation, like an evalu, that you recall?

Are you there?

DR. PAPIN: Are you asking me a question?

DR. WILLIAMS: Yes, yeah.

DR. PAPIN: I'm sorry. It's difficult to hear you.

DR. WILLIAMS: No. That's all right.

I was asking when was the first time that you say an evalu, that you read an evalu, that you recall.

DR. PAPIN: On or about probably the beginning of the second month, so August of 2016.

DR. WILLIAMS: And do we have those evaluations?

DR. BONDI: This is Dr. Bondi.

There is -- 17, 18, 19. And they're aggregated as -- which is the way we usually see.

I can tell you that as a CCC member in the department of pediatrics critical care, that's the way we see them, as aggregated. We don't see the

individual evaluations.

DR. EARL: Those -- those are the milestones.

DR. BONDI: I'm sorry. What was the date, Marc?

DR. EARL: November the 8th, was when the milestones were put into the ACGME system.

DR. HOUSTON: So the meeting was before then?

DR. EARL: Typically, a couple of days or a day before.

DR. BONDI: All right. Who would you -- who would you like to have us listen to next?

DR. EARL: Meghan Mahoney.

(Off the record.)

DR. BONDI: Dr. Mahoney, we've met before. I'm Steve Bondi. You'll remember me from the PICU.

You understand why you're here, correct?

DR. MAHONEY: Yes, sir.

DR. BONDI: Okay. So this is an informal process. What's going to happen is, is that Dr. Earl is probably just going to ask you to tell what you're here to tell us. The committee members may ask you some questions. And then Dr. Papin is on the phone. He's not going to ask you questions

directly, but he's going to have an opportunity to respond, and then we may ask you questions. So he's not -- there is not going to be a cross-examination or anything like that.

DR. MAHONEY: Sure.

DR. BONDI: Just so you understand.

So do you have anything specific where you wanted to start?

DR. EARL: Yeah. So I guess what I would be interested in is specifically telling us the events surrounding your experiences: Number one, the issue of when we left the hospital -- or when we -- we -- Dr. Papin left the hospital to go exercise while on your service, what you knew about that, if you gave permission to do it, and then the events around the patient that had the decubitus ulcer and what you were told by him.

DR. MAHONEY: In regards to the exercising, I was in the operating room, and when I got out, I saw that he had sent a text about 30 minutes earlier, asking -- or really just saying, "I'm going to go for a run if that's okay with you. I'll be readily available; I'll have my pagers."

And when I saw it, I, you know, sent a text saying, "Are you -- are you joking?" And he

said he was. And I said, you know, "That's not okay."

So I didn't give him permission. He said he didn't go. But I just found it very unprofessional for him to ask to go running during hours when he's in-house and he is first call for trauma.

DR. LUZARDO: Was he expected to be in that surgery?

DR. MAHONEY: No.

DR. LUZARDO: I mean, you were in the OR?

DR. MAHONEY: I was in the OR; he was not expected to be in the OR.

DR. BONDI: And this is Dr. Bondi.

Was that the first time you and Dr. Papin had ever discussed exercise or leaving to exercise?

DR. MAHONEY: To my remembrance, yes.

DR. HAYNES: And you never -- Demondes Haynes.

You never gave him permission to leave while he was on call?

DR. MAHONEY: No, I did not.

DR. LUZARDO: Was that surgery from your service or was that surgery for somebody else that you were helping operate?

DR. MAHONEY: It was a trauma surgery. It was a trauma operation.

DR. EARL: Your service?

DR. MAHONEY: Yes, my service.

DR. LUZARDO: Would you say that any other intern would have been generally expected to show up to that surgery?

DR. MAHONEY: No, not necessarily. There's a midlevel that usually would help me. And the interns, they're very -- because there's a -- it's a large patient census, so they are expected to, you know, work on trying to get the patients discharged and --

DR. LUZARDO: So there was nothing going on, so that's why he --

DR. MAHONEY: I also didn't have them come in if they were first call, because they would get all the floor calls. So I didn't want that to be in the operating room.

DR. EARL: And then what -- tell us your -- when -- or what your experience was with the patient that had -- that wound up having a decubitus ulcer that was on your service, the events -- the timeline and events that lead up to it. When did Joe take over caring for the patient, what were the

questions that were asked and what were the answers that you received?

And you can refer to Bates Page 9, Number 9.

DR. MAHONEY: So because I was in ICU for a year, I was very familiar with decubitus ulcers. And knowing that we had a lot of patients on the trauma service, some of which were quadraplegic, paraplegic and could be in-house for a long period of time, I had pretty much an unwritten rule that the interns were told at the beginning of the month, "I want nutrition, labs and the patient's looked on the backside by you every Monday." Just a specific day, do it every Monday, you know, no questions asked.

So on this particular patient, on rounds, I asked if he looked at the backside, and he said, "Yes, everything is okay." A week later, he -- I asked, again, and he said it was okay.

And then, we had -- went into the holiday schedule, and he sent a text -- he was getting ready to leave for the day, I believe, and he sent me a text saying that he put in antibiotics -- or the recommendations for -- wound care recommendation for this person's early decubitus ulcer. And because he

said "early," I thought this was a new finding. He's been telling me everything was okay. So I made a note to look at it on rounds the next morning.

I looked at it on rounds, and it was very large. I could stick my whole hand in there. We ended up having to take the patient to the operating room to debride it. He ended up getting a (unintelligible)ostomy.

And it was a very extensive wound. So I -- you know, in my opinion, I don't see how that could have formed in the week that we had talked.

DR. LUZARDO: Well, let me follow with that. He has stated -- the implication was that he, perhaps, had not actually examined it. He stated that he did. However, it was a gap of knowledge, that he saw a scab and he didn't make much of it. Eventually, you know, by leaving it in the scab, you did, you found out there was a crater.

So the only question is: It is possible -- is it possible that that's the case, that it can't be seen and interpreted as a -- you know, there was maybe a little pressure but not -- that it was a gap in knowledge as opposed of that he didn't examine it? Is that possible?

DR. MAHONEY: I asked them to let me know

if they saw anything, so -- because I understand that interns may not have that knowledge, so I wanted to know -- and I told them to let me know if they saw anything.

DR. LUZARDO: When you saw it, did it have a scab on top of it?

DR. MAHONEY: It had a palm-size eschar, yes.

DR. LUZARDO: Okay. And it was black?

DR. MAHONEY: Yes.

DR. LUZARDO: Okay.

DR. WILLIAMS: Nilda Williams.

By anything, you mean -- I mean, everybody knew that this patient had a wound, the nurses, or did nobody even know that he had a wound?

DR. MAHONEY: I did not know he had a wound, no. And that's why I put that rule in place because there are so many -- so many patients, and with operating, I could not look through every patient's chart and at every patient. So I relied on these residents to let me know. And that was it, let me know.

DR. WILLIAMS: So anything and all is anything?

DR. MAHONEY: Anything. Whether it's red

or you know, necrotic.

DR. WILLIAMS: I don't know if I can ask this question. I like all the objective facts and everything, but I know Meghan pretty well and I've worked with her for a good while. Can I ask you subjectively, do you feel that this termination was just?

DR. MAHONEY: Yes.

DR. BONDI: Anything else you'd like to add? Dr. Earl, is there anything else you would like her to cover -- Dr. Mahoney to cover?

DR. EARL: Just give me 30 seconds.

What was your -- what was the feedback you received from nursing staff on the trauma floor during that month?

DR. MAHONEY: So 3 North is pretty much the trauma floor. And I've known a lot of these nurses for years, since I was an intern, and they, on one occasion in particular, found me -- two of them found me, wanting to talk about Dr. Papin. Another nurse overheard us talking and she said, "Who are y'all talking about?" And I said, you know, "Papin." And she made an expression like, "Oh, my God." And then the next thing you know, there are several people there.

And it -- it was obvious that it was an issue. They said he was very unprofessional, they felt like he wouldn't listen to them. And I've -- I've really never had that many nurses come to me about a particular resident.

DR. LUZARDO: Did you ever communicate any of this to Dr. Papin?

DR. MAHONEY: To him?

DR. LUZARDO: Yes.

DR. MAHONEY: Yes. In fact --

DR. LUZARDO: You directly?

DR. MAHONEY: Yes. I talked to him multiple times. And I recognized his lack of professionalism. Many of his characteristics were an issue, to the point where I was having to say it multiple times and I did not want to embarrass him in front of people, so we came up with a numbering system where, you know, one was, you know, being rude, and went down to -- I believe it's five. I can't remember all of them.

But if we were in front of people and he was exhibiting that behavior, I would say, "Joe, Number 2." It got to that point where I felt it was necessary to create a numbering system.

DR. BONDI: Can you remind us what month

you're talking about?

DR. MAHONEY: This is December.

DR. BONDI: December of '16?

DR. MAHONEY: Yes.

DR. BONDI: Okay.

DR. EARL: Sorry. I lost my train of thought there. And then do you have -- oh, sorry. Go ahead, Demondes.

DR. HAYNES: Dr. Demondes Haynes.

Do you have students on the service?

DR. MAHONEY: Yes, we had two.

DR. HAYNES: And other residents?

DR. MAHONEY: Yes.

DR. HAYNES: Did they give feedback from that month about Dr. Papin?

DR. MAHONEY: One of the med students found me and conveyed to me that -- it was really about unprofessional behavior, and one of the reasons was there was a female med student that had become uncomfortable around him. And this male med student came to me and said, you know, "This is a problem; I'd like to talk to you about it."

And I did -- the other male resident -- the other intern, I asked him if Joe was -- if they worked together, if Joe was helping him or if he was

gone for long periods of time, and he said that there were long periods of time where he didn't know where Joe was but could not prove if he was on campus, off campus or whatnot. So I didn't chase that any further.

DR. HOUSTON: And so the numbering system was mapped to specific behaviors, like each number was a specific thing?

DR. MAHONEY: Uh-huh (affirmative response).

MR. WHITFIELD: For the record, nods and "uh-huhs" don't translate on the paper.

DR. MAHONEY: Yes. Yes, it was.

MR. WHITFIELD: So please answer "yes" or "no."

DR. MAHONEY: And I remember -- I can't remember all of them or the specific numbers that they were applied to, but it was things like being rude, showing attention to detail and lying.

DR. BONDI: Unless we have -- unless we have something else significant to add, I'd like to give Dr. Papin an opportunity to once again address the committee about the things that Dr. Mahoney has said rather than direct her.

(Off the record.)

DR. BONDI: All right. Dr. Papin, this is your opportunity to respond to the committee about what you've heard Dr. Mahoney say.

DR. PAPIN: Yeah. Can I have a minute to speak with Joel?

DR. BONDI: Yes, that's -- let's do that.

MR. DILLARD: A short minute, a 30-second minute.

DR. BONDI: Okay. So we're going to go off the record for a moment.

(Off the record.)

DR. BONDI: All right. Dr. Papin, it's your turn.

DR. PAPIN: All right. Again, I'll -- I'll talk about the issues on a case-by-case basis.

So on the issue as I had previously stated about the fact that I had been asking to go running, I'd like to read from my own text messages -- my attorney or whoever, we can provide you the evidence that I've attempted to share many times now.

But on Tuesday, December 6th, at 11:44 a.m. -- I'm going to read a text message between myself and Meghan Mahoney. I'm going to read what I said. "Vascular said we can leave the drain in for Scott and follow up in one week. Still waiting for

the word" --

DR. BONDI: I'm sorry. Let me stop you. Can you be a little slower, please, so the reporter can catch everything down, please.

DR. PAPIN: Certainly, certainly.

DR. BONDI: And speak up because you're a little muffled, because I'm sure you're reading from the phone you're talking on.

DR. PAPIN: Right.

DR. BONDI: Okay.

DR. PAPIN: I'm reading a text message conversation between myself and Meghan Mahoney. This text message is dated Tuesday, December 6th, at 11:44 a.m. And I'm about to read what I said. "Vascular said we can leave the drain in for Scott and follow-up in one week. Still waiting for word from home health. Is it okay with you if I go for a run around campus with my pagers and cell while it's dead."

And then she responded, "As long as pagers work," to which I responded, "Thank you."

DR. BONDI: All right. Thank you.

DR. PAPIN: Certainly.

And then, the next time is what she describes where asked if I could go and she

(unintelligible) that information.

The next issue is --

DR. BONDI: I'm sorry. What was the -- what was the date of the follow-up text about running?

MR. DILLARD: Read those. Read those.

DR. PAPIN: I would have to -- I would have to pull that up, the exact time of the responses. They were almost immediate. I mean, when I provide that for you, I'm sure I can get the -- when it's provided there will be date information. I just don't have it right now.

DR. BONDI: Okay.

DR. PAPIN: But I mean, there was an immediate conversation. There was a text message, and then within minutes she responded, and within minutes I responded back.

DR. BONDI: No. I think what we're talking about was -- we talked about the December 6th conversation. I was talking about the subsequent conversation, where she told you you weren't allowed to go running. That's what we were asking about.

DR. PAPIN: Oh, okay. Yeah. Again, I have a picture of the text message conversation,

where it shows where it started, but I don't have the -- I would have to physically go and find it.

MR. DILLARD: Read -- read it, Joe.

DR. PAPIN: Oh, certainly.

So on Thursday, December 15th at 3:20 p.m., I texted Meghan, "Going for a run with my pagers if that's all right with you. I'll be in constant contact if it's okay."

Then she responded, "Excuse me?"

I said -- and then I responded, "I didn't go."

And she responded, "Like exercise?"

And then I said, "I'm asking, though. Ha, ha. Everything is done on my end, yeah. Got some sense from Goodson's son."

Then she responded, "Are you fucking kidding me," to which I responded, "Yes."

And then she responded, "I will give you all the reasons why that is not okay later, but number one is you're first call."

DR. BONDI: Were you first call on December 6th?

DR. PAPIN: Yes, I believe so.

DR. BONDI: Okay. And you wanted to address something else as well?

DR. PAPIN: Yes, the decubitus ulcer. Again, I don't have access to the electronic medical record anymore, but I do know that this patient in question had the decubitus ulcer before I -- I came on service. And again, I wasn't the only intern or nurse practitioner that saw this patient. But he had it documented before I even began the rotation. So, in fact, I'm actually the first person, I guess, to have reported the decubitus ulcer to Meghan.

And then, I can read you another text message conversation to further confirm that, you know, she was at least aware.

So I left on my Christmas vacation on December 20th, so Thursday, December 22nd was the last day. Then I went on a five-day Christmas vacation.

At -- on Friday, December 23rd, at 9:07 a.m., Meghan texted me, "Hope you made it safely. Sorry to bother you, but who had key sacral decub wound, Holder or Newsome?"

I responded within five minutes, "I did make it safely. Newsome is 311, has an eschar at the moment and wound care saw him yesterday and recommended to continue SANTYL."

DR. BONDI: Do you have anything else to

add -- oh, sorry.

DR. PAPIN: Yeah. I mean, I had been seeing the patient. We had been communicating, Meghan and I, and I had told her that -- that the black eschar that was there was there, and I just didn't know that you had to peel it off and that would reveal the -- that the underlying decubitus ulcer just didn't look that bad to me. It was just a black scar on someone's back.

And moreover, the wound care team had also been following him and actually dropped in the notes with pictures. And I told that the note was in from them and also the note contained pictures on December 22nd, the day that I left for Christmas vacation.

DR. BONDI: All right. Does anybody else --

DR. PAPIN: Oh, go ahead.

DR. BONDI: I'm sorry. Please go ahead.

DR. PAPIN: The next issue is the nursing complaint. Again, this was another situation where I was never privy to any of these complaints. Nobody complained to me directly. I never saw it happen.

But I do know that nurses had been

confusing the other intern on the service, Dr. Will Brooks and I. Meghan actually said this to me directly. And Will had said the same thing, that the nurses were confusing him and I frequently. I guess we have similar heights, similar build, I guess looked similar. So we had been getting confused. But the fact -- and he had been getting several complaints that were attributed to him and I guess I had several complaints that were actually him or were actually about him but were attributed to me. So there was a lot of back and forth on that, I know that.

Meghan also wrote that she didn't want to embarrass me and -- but had devised the number system. She did, in fact, devise the number system. The embarrassment was frequent with her. She -- her nickname in the department and I mean, this is well-known was the "Red Dragon," which she's earned by being just difficult to deal with.

She would embarrass me frequently. It happened so often, so frequently in public that one day we were in the radiology reading room adjacent to the emergency room, down in the ground floor, and there were orthopedic surgery residents down there, there were other interns, there was a urology

resident down, she was down there, I was down there, there were radiology techs. I can't remember or not if there was an emergency medicine resident down there or not. But needless to say, it was -- it was pretty multi-disciplinary down there.

And for whatever reason I can't recall, she felt the need to publicly embarrass me by giving me some sort of feedback that --

So I told her plainly that I disagreed with the way that she gave feedback and I would prefer it to be done privately. So she became irate, which happened on an almost daily basis, and pulled me outside. And I expanded on it and I told her, you know, you doing this is, you know -- I appreciate the feedback, and I'm happy to improve with whatever, but you doing this in front of orthopedic surgery residents, you know, emergency medicine residents, if they weren't there at that time, it was in front of them several other times. Urology residents -- I mean, it's embarrassing for this to get outside of the surgery department. I asked her if she would please stop that. She didn't, but she devised that number system.

Again, I don't exactly recall the number system. One of them was never lying. I mean, it

doesn't even make logical sense. She would blurt out a number that would indicate that I was lying to her. I don't understand how that makes logical sense.

But another number was that I was being a douche. That one was a frequent one. I think that was Number 2.

So she would say two, and that was my cue that I was being a douche. And most of the other numbers were in the same thing. Just, you know, a way to embarrass me because everybody else knew the code. She wasn't hesitant to hide the code. I guess it was just a shorthand to save herself breath.

And then the last issue is this issue of the mail med student, the female med student. I'm not sure what that is. Again that -- the very first time I had read about this was at all was the documents that were sent to Joel Dillard, my attorney. It was never brought up to me. This would be the first time I certainly hear about. And then the first time I've read about it, again, was in those documents.

DR. BONDI: Do any of the committee members have any further questions for Dr. Mahoney,

based on what we've heard in the last few minutes?

DR. LUZARDO: Do you run on campus or outside campus?

DR. PAPIN: On campus, sir. Just the once, but yes, on campus.

DR. BONDI: Any questions for Dr. Mahoney?

DR. HOUSTON: Joy Houston.

So Dr. Papin alluded to an incident of feedback in front of others. Do you recall what he's talking about?

DR. MAHONEY: I do remember that particular instance at the radiology reading room. We were inside -- a patient was being scanned, so we were inside the area where you look at the monitors. I don't remember exactly what he did, but I asked him to step out into the hallway so I could talk to him. And when we were in the hallway, there may have been people that passed by at some point that were the other residents. So I just did not want to do that in front of the team.

DR. BONDI: Any other questions?

Thank you.

DR. MAHONEY: Thank you.

DR. BONDI: All right.

DR. EARL: I think one of the things that

I wanted to -- since it's sort of the -- the "Red Dragon" nickname was with -- that was given to Meghan when she was an intern by the chief residents that were above her that have been some of our most respected residents that have finished here. I think that's important to know. That was not something she earned last year by berating interns.

The other thing is that last year with Will Brook and Meghan Mahoney, I dealt with zero instances of interprofessional behavior issues with the both of them combined.

DR. BONDI: Thank you.

I would like to start with the next witness, and then we'll use our break time to allow Dr. Papin to talk to his attorney about that witness so that we can have some efficiency there, if that's okay with everybody.

So we're going to get the next witness, who's going to be?

DR. EARL: Ashley Griffin Ray.

Are we off the record?

DR. BONDI: We can be if you'd like.

DR. EARL: Oh, no. I'm fine.

DR. BONDI: No. You're fine.

So I'm Steve Bondi. I'm chairing the

committee that's hearing this appeal of a termination. It's an informal hearing. The way it's going to go is that Dr. Earl is going to ask you some questions about the issues that we're talking about.

DR. RAY: Okay.

DR. BONDI: The committee members may ask you some questions. Dr. Papin is conferenced in. He's not going to ask you anything specifically. He -- he has an opportunity to respond to what you said. The committee members may ask questions based on that.

DR. RAY: Okay.

DR. BONDI: Okay.

DR. EARL: So the first incident I would like to ask you about is the incident that I think you were, at least, there for part of it, of whenever he was asked to come back to a patient that was coding. And can you just tell us about what -- what happened then?

DR. RAY: Yes, sir. So the interns typically start their shift at 6:00 prior to the new intern rule where they can take 24-hour call again on night float. So Joe was on trauma at that time. They sign out of 6:00. It was, I believe, 5:58 or

5:59 when a Code Blue was called overhead.

Dr. Papin had already signed out to the oncoming intern but the shift wasn't officially over, and he had signed out "no issues with his patient." However, the patient that was coding was his patient on the floor.

Normally, our -- our department's handling of codes is if you hear a code called, we immediately call the floor as to where the code is taking place to see if it's a surgery patient. If it's a surgery patient, we immediately go, no matter if you're on or not. Whoever is able to be mobilized goes to the code, whether it's your service, after hours, et cetera.

Dr. Papin admits that he heard the code being called overhead, did not check in to see that it was one of his patients, was then notified that it was one of his patients and asked to come help because the sign-out that was received was the patient had been fine. And then said that he had not received the code or been made aware to me until after the -- he was in his car. He did not come back to help.

And then, there is a series of text messages that were exchanged between he and the

intern that were actually on -- was on that night, that I believe are included in the -- in the packet.

DR. HAYNES: Demondes Haynes.

What year resident are you?

DR. RAY: PGY 5.

DR. HAYNES: So you were in-house this night?

DR. RAY: I was the chief on-call that night, uh-huh (affirmative response).

DR. EARL: And did he offer -- when asked to come back, did he offer to come back, to your knowledge?

DR. RAY: No. He said he was already in the parking garage when he was made aware of the code.

DR. EARL: Okay. And then what -- what is your knowledge or -- do you have any about not rounding on patients prior to start of -- prior to rounds with the senior residents or starting a day shift?

DR. RAY: Yes, sir.

DR. EARL: Or starting a day.

DR. RAY: Actually, my experience with this was during the holiday split. We do a split where half the residents work the Christmas holiday

split and half the residents work the New Year split. Y'all may have already heard some of this; I'm not sure.

And I actually was working straight nights at that time. So I was rounding on trauma in the morning with Joe prior to leaving for a few hours and coming back at 5:00. And I told him he needed to be ready at 7:00 to round with me and staff and we would be rounding at 7:30 with our staff.

He told me he was ready to round several times, and I was pulled aside by the medical students who, then, informed me that he had not seen any patients. And it is out expectation that the interns see all the patients prior to rounding with staff, and if they do not do so because traumas come in and we get busy, then they need to be honest and forthcoming that they have not seen the patients.

I was told that he had seen everyone and that he was ready, but then I was pulled aside by a medical student who had informed me otherwise. And this happened during the week of the New Year's/Christmas holiday split.

DR. EARL: Did you ask him if he had seen everybody?

DR. RAY: He said, "Yes, I'm ready."

Those were always the answers.

DR. HAYNES: Did you have any other instances -- Demondes Haynes -- where he said he had seen patients but you thought he had not?

DR. RAY: No, sir, I didn't work with him directly very much.

DR. EARL: Just during the holidays?

DR. RAY: Just during the holidays.

DR. WILLIAMS: Nilda Williams.

So are you implying by his answer that, "Yes, I'm ready," that he indirectly answered to say, "Yes, I saw the patients and I'm ready"?

DR. RAY: Yes.

DR. WILLIAMS: He just (unintelligible)?

DR. RAY: Yes. He never, I guess, directly said, "I've seen every one of the patients," but that is our expectation of our interns or our residency. If we say we're ready, that means that while surprises may happen with rounds and with staff as we all are experienced with, he has seen every patient and is ready to walk around.

DR. BONDI: All right. Anything else for Dr. Ray?

DR. EARL: No.

DR. BONDI: All right. So we'll take a pause. We'll go off the record now and we'll let you talk to Dr. Papin.

And we'll take -- I'd like to say five minutes -- I understand it may be a little bit longer -- to just let people refresh themselves.

(Off the record.)

DR. BONDI: The first thing is, I wanted to comment --

MR. DILLARD: Check to see that he's there.

DR. BONDI: Dr. Papin, are you there?

MR. DILLARD: Because he said he had to step out to the restroom.

DR. BONDI: That's very reasonable.

Well, let me just state the other administrative thing, which I don't think he needs to hear -- you can fill him in on that -- is that Dr. Luzardo had to step out. So he stepped out at about 6:05, so that's about 15 minutes ago. I just want to let everyone know that we still are well within our quorum of individuals for the committee. And I'm sorry about that.

But are you there, Dr. Papin?

DR. PAPIN: I am now, yes.

DR. BONDI: Okay. All right. There was just one follow-up thing that Dr. Ray wanted to add -- or Dr. Earl wanted to ask of Dr. Ray.

DR. EARL: Yes. I wanted you to actually just comment on your -- your experience with the -- the wound and the trauma patient that happened while you were a senior resident on that service.

DR. RAY: Yes, sir. Again, this was -- I was on night float sometime -- I believe it was in November or December, sometime around the holidays. I don't remember the exact date. And again, we had a patient that had a very large torso and upper extremity wound that resulted in an upper extremity amputation eventually.

But Joe was instructed to wash the wound out while the patient was in the intensive care unit. He was on during the day. And about midnight, I was actually paged by the ICU nurse practitioner because this had not been done yet. So I personally washed the wound out at midnight and pulled grass and dirt and gravel out of this wound.

And I -- I told his chief resident the next morning, I irrigated and packed the extremity and torso. And that's all. So just a delay in patient care.

DR. BONDI: When asked about that before, Dr. Papin said that he did wash the wound out and that he recalls being in the room at the same time that an ophthalmology resident was suturing the patient's eyebrow, eyelid, something optho would do.

DR. RAY: I was called by the nurse practitioner who said that she had not witnessed the wound being washed out, the night nurse had not seen the wound being washed out and the nurse who had come on -- or was on prior to 7:00 shift change said the wound had never been washed out.

DR. BONDI: So in your opinion, as the person who looked at the wound and washed it out, do you believe that it could have been washed out but washed out poorly rather than not washed out?

DR. RAY: I would -- I -- no. It was dirty.

DR. BONDI: All right. Do any of the committee members have any questions for Dr. Ray before Dr. Papin addresses his concerns?

DR. HOUSTON: Just a follow-up.

I mean, even if the wound had been washed out poorly, you said that you washed it out and packed it, so you would expect a poor washout would be followed by packing, right?

DR. RAY: It was not packed. It was a loosely placed dressing that had been, obviously, placed in the trauma bay. The wound had not been packed with Betadine, for example.

DR. BONDI: Okay. Dr. Papin, you're free to address any comments to the committee based on what you've heard Dr. Ray say.

DR. PAPIN: Thank you.

I'll start with the Code Blue. I -- I had already signed out. I did not -- there were no issues with my patient. I believe the comment was that there were no issues with any of my patients. Certainly, not with any of them and also certainly not with that particular patient, either.

At the time -- I'm not sure if everyone is familiar, I'm sure most are, but the -- Code Blue was called, and if it was Code Blue, it will give a rotation. It doesn't say a specific patient room or anything like that. So when it happened, I was down there with the entire night team. Nobody rushed out, nobody sat down -- and Dr. Griffin said it was standard. Nobody sat down and called -- at least while I was there, called the unit to see who the Code Blue had been called on.

So I -- I thought nothing of it and just

walked out to my car. Nobody at any point called me and -- or asked me to return. I certainly would have turned around if I had been asked to return.

There's -- in the documents that were sent, there's a text message conversation between myself and Erin Moore who is the night intern who I had signed out to. But the person who had actually texted me first and the person who was actually there was the other intern on the service, Will Brook. And I'd like to read the text message conversation or exchange between us.

On Monday December 12th, at -- or well, it's saying 6:59 p.m., which standard time now, and I think that the iPhone adjusts for that. So this must have been at 5:59 p.m., Central. He wrote or he said, "They just called a rapid on (unintelligible)."

And I responded, "Oh, shit. What happened? I'm already gone. Can you let me know how he's doing?" And this was at -- my phone says 7:07, but that must have been 6:07.

And then he responded, "Yes, sorry. I was running to grab a (unintelligible). They think he aspirated. They called a Code Blue initially, but it took a while for him to get intubated."

So that was the exchange between me and Will, and that was the first time that I had been notified of anything. And again, nobody was asking me to come back. And then the exchange that's already printed out for you guys, Erin texted, "You know your patient was coding before 6:00" -- with ellipses, dot, dot, dot, and that was at 6:15 p.m. To which I responded to him, and that's all there.

So at no point was I ever called. I do not know that this was on a patient that I had been seeing. And while I was down there, the night team was there and you know, no -- it's not like anybody started sprinting for the door, going towards the unit and anything like that. There were no phone calls made to the unit to figure out whose patient was whose, and frankly, nor have I ever seen that done. But when I was made aware of it, I took responsibility for it and you know, I realized that yeah, three north or the third floor had a significant concentration of patients. And from that point forward, if something like that had happened, I would have known, but (unintelligible) people are just absentmindedly continuing to walk out the door.

DR. HAYNES: This is Demondes Haynes.

Were you -- were you still on campus when you --

DR. PAPIN: I'm not able to hear you too well.

DR. HAYNES: I'm sorry. Dr. Papin, this is Demondes Haynes.

Where were you when you were notified that the patient was coding? Were you still on campus?

DR. PAPIN: When I -- when I received the text message, I was no longer on campus. But when I -- I mean, I overheard -- I heard the Code Blue being called, but again, there's no specificity to those Code Blues other than the unit.

DR. HAYNES: Okay.

DR. BONDI: Do you have anything else to add at this time?

DR. PAPIN: Yes. So on the issue of seeing patients. There was a medical student who informed Ashley, I guess, that I had not rounded on patients beforehand. Again, categorically, that never happened, meaning that I -- there was never a time where I didn't see patients in the morning and claim that I had or claimed that I was ready to see patients when I had never seen any of them. I saw patients -- from what I understood from Dr. Griffin,

they were saying that they hadn't seen me do it. It's not standard for residents to check in with medical students after sign out or you know, to alert them that they will be rounding in any way. So I just went to work immediately.

And then the last issue is the washout. So again, that's that washout -- as I said previously, there was an ophthalmology resident in the room with me who I'm certain once we looked up who that was, you can ask. But also I had a text message from the chief who on duty at that time and myself. His name is (unintelligible).

On Tuesday, December 27th at 6:25 p.m., he texted me, "You washing the shoulder out or what???"

And again, this 6:25 p.m. is what you'll see because I'm on Eastern standard time, so this is 5:25 p.m. And then I wrote, "Already did it. It's washed and packed. I left two minutes ago."

And then from what I remember, the next day or whatever day I heard about this, it was that -- I don't know, for whatever reason, I don't know, but they didn't think that I had actually done it. So Sid had done it himself. So for me to do it, then Sid to do it, and then Ashley to see it at a later date, which is my understanding, at that

point -- there were three packings at that point, the initial one, mine in the ICU and then Sid's in the ICU. And then Ashley for her to say she was pulling out dirt and gravel and all this, I don't -- I can't speak to that.

But I believe there was at least two. Well, I know there was at least two: The initial one and mine, and then I believe Sid did another one.

DR. BONDI: Do you have anything else you want to add about Dr. Ray's comments?

DR. PAPIN: No.

DR. BONDI: Okay. Do any of the committee members want to address anything that Dr. Ray has said or that Dr. Papin has commented on Dr. Ray?

MR. ASFOUR: Dr. Papin, in your opinion, why do you think they are saying what they say? It's your word or their word. Why do you think they saying that? They just don't like you?

DR. PAPIN: I can't comment on the opinions of other residents.

MR. ASFOUR: Okay. Thank you.

DR. BONDI: Anyone else?

DR. WILLIAMS: Nilda Williams.

Is it possible that y'all are talking

about different patients or something?

DR. RAY: In this code instance?

DR. WILLIAMS: No, not --

DR. RAY: Or in the shoulder? No.

DR. BONDI: Any other comments or questions?

DR. WILLIAMS: Just regarding the code. Does he have any animosity with the resident that he received the sign-out from?

DR. RAY: Not prior to this. Nothing was noted that I -- that I would be aware of. It seemed like a very normal, professional relationship.

DR. BONDI: All right.

Thank you, Dr. Ray.

DR. RAY: Thank you.

DR. EARL: To assist the court reporter, this is Colin, C-O-L-I-N, Muncie, M-U-N-C-I-E.

DR. BONDI: I'm just going to -- I'm Steve Bondi. I'm the chair of the committee. Just to briefly say what we're doing: Dr. Earl is going to ask you some specific questions; you're going to be able to say -- answer those. Then we're going to ask Dr. Papin to comment to the committee, based on what you said. He's not going to ask you any questions. The committee may ask you some

questions.

DR. MUNCIE: Yes, sir.

DR. EARL: All right. Please just tell us, in your own words, what your experience was with the events of admitting a patient to ICU and then how that -- all that transpired.

DR. MUNCIE: So on a Saturday on call during the late daytime, I had instructed -- instructed Dr. Papin to put in admission orders for a critical patient in the ER and for him to communicate to the ICU that the patient would be coming, which is kind of standard protocol on any patient in the -- on the trauma service.

At the end of the shift, I had been notified by the ICU that they did not know that this patient was coming and that they were surprised when the patient arrived.

When I confronted Dr. Papin, he confidently told me that he had spoken to someone in the -- in the -- in the resident work room and that they were aware the patient was coming.

When I went back to the ICU and found the senior nurse practitioner who was on call for the daytime, I asked her to try to find out who Dr. Papin had talked to so that we could confirm

that he had, indeed, communicated to the ICU, and she was unable to identify anyone that had spoken with him about that particular patient.

DR. WILLIAMS: Nilda Williams.

Is it possible that the person he had spoken to left, like, shift change?

DR. MUNCIE: So it's possible -- you know, I was depending on that nurse practitioner to extensively talk to everyone who was on call so -- and I did not perform those interviews, so I can't really speak to that. I was --

DR. WILLIAMS: So that person would have signed that out to the next person?

DR. MUNCIE: Yes, yes.

And I think that -- that Dr. Papin had brought up at one point that, you know, he may have spoken to a nurse, he wasn't sure. He couldn't tell me who he had spoken with.

DR. WILLIAMS: Speaking to a nurse?

DR. MUNCIE: No, that's not usually standard protocol.

DR. BONDI: Anything else?

DR. EARL: No.

DR. BONDI: Dr. Papin, your response to that?

DR. PAPIN: Sure. Just give me 30 seconds, please.

DR. BONDI: Okay.

MR. DILLARD: You need to talk to me, Joe?

DR. PAPIN: Yes.

So I agree with everything Collin said. I don't recall nor do I think that I ever said that I communicated with a nurse. But other than that, everything -- everything is factual there.

And the only other follow-up question that I would have, is how many times has it happened where somebody has said that they communicated with the ICU and they have denied or you know, some medical error or some error has occurred, a break in communication where the ICU wasn't notified for whatever reason?

I'm just curious how often that's happened.

DR. BONDI: Okay. Any other comments or questions for Dr. Muncie?

Thank you.

DR. MUNCIE: Thank you.

(Off the record.)

DR. BONDI: I'm Dr. Bondi. I'm chairing the committee for this appeal.

Dr. Earl is going to ask you some questions. You can answer those. Dr. Papin is going to have an opportunity to comment on those. He's not going to ask you any direct questions. The committee may also ask you some questions.

MR. RAY: For the court reporter's convenience, this is Dr. William Crews, C-R-E-W-S.

MR. CREWS: Medical student.

MR. RAY: I'm sorry.

MR. CREWS: Currently fourth-year medical student. Third-year medical student.

MR. RAY: William Crews, C-R-E-W-S.

DR. EARL: Yeah, William. Thank you for coming.

Tell us your experience when -- about seeing Dr. Papin and your experience with him seeing the patients in the morning and how he communicated with the senior chief residents about patients he had seen while you were on the trauma service last December.

MR. CREWS: So I get there pretty early in the morning with my partner, a fellow M3. We would go through the list, work through it. And generally, they would ask us to round by a certain time.

And it wasn't always, but sometimes Dr. Papin would show up maybe later than he needed to, in order -- trauma is a huge service, he had a lot of patients to see. And we would be rounding and he wouldn't have seen some of the patients, but he would report on them. And it just alarmed me that that would happen, and that happened.

DR. EARL: And was there other residents that were there working during this time and seeing patients while you were -- while you were there pre-rounding?

MR. CREWS: I believe Will Brooks would -- he would some patients before then. Do his best to see his patients, as well.

DR. EARL: Okay. And you saw Will those mornings?

MR. CREWS: Most of the time, I believe so. We were all in the work room. He would -- he would come in and grab our list sometimes before we would finish the list and do his best to see some patients.

DR. EARL: Okay.

DR. HAYNES: Demondes Haynes.

About what time would you get there?

MR. CREWS: 3:30 a.m.

DR. HAYNES: And about what time would Dr. Papin get there?

MR. CREWS: It -- it varied. Some mornings it would be 5:00 a.m., some mornings later. I think one morning it was after 6:00. There were just times that I noticed, especially mornings during the holidays, that's when we were working, that -- and I would be working with Dr. Griffin, that there would be short staff and we'd have to round at a certain time, like 7:15. And Joe said that he had seen his patients by 7:00 and he was just getting there.

DR. BONDI: How many days do you think you worked together total?

MR. CREWS: So I came in as an M3. We have different rotations than the residents. I believe I worked with him for maybe a little over a week. But perhaps, seeing all this, I had been -- I had worked with him before and didn't see a problem, but a big patient load, I think that's when I noticed it. And I felt like I should say something because I had been warned multiple times for my classmates about his behavior.

DR. EARL: What -- you had been warned about what by your classmates?

MR. CREWS: That Joe gives false reports on patients, and if he makes a mistake, he'll blame it on the med student sometimes.

DR. EARL: What was the -- you mentioned in your e-mail some interaction between -- or some feelings of -- some interaction of Joe and a female medical student. Could you describe that to us, your co-medical student that was on service with you then?

MR. CREWS: So, you know, I wasn't quite with her all the time, but she expressed to me that she was feeling very uncomfortable with Joe. I didn't -- you know, it was kind of a sensitive of topic. I don't think Joe ever made any physical moves on her, but there were times when it was our duty to see patients, especially on the trauma team as two medical students, and Joe would go out of his way to where it would just be him and my female partner rather than me and my -- me and my medical student partner to go see patients.

DR. BONDI: Okay. Do you have anything else to add, Dr. Earl?

DR. EARL: I don't.

DR. BONDI: Do any of the committee members have any questions for Mr. Crews?

DR. HOUSTON: Really quick. Joy Houston. So from what you're saying, Dr. Papin had already developed a reputation within the M3 class before you ever got to the rotation?

MR. CREWS: Yes, ma'am.

DR. WILLIAMS: And this was passed along through how many groups of students as far as you're aware?

MR. CREWS: So I would -- so we started in June and by the time I got there, this was late November, December.

DR. HOUSTON: And that was a consistent report from like every group from day one?

MR. CREWS: So I mean, you know, I can't say I communicated with every single previous surgery group, but his name came up frequently, saying, you know, "If you don't want to get screwed over, watch out." And I personally didn't ever have a problem with Joe, but some of the behavior, I did see. And I think after taking an oath, I felt like I should say something.

DR. BONDI: Dr. Papin, would you like to respond to the committee based on what you heard Mr. Crews say?

DR. PAPIN: Certainly.

He stated that I arrived maybe later that -- referring to me. I'm not sure what that means. But again, you're arriving sign out. You get signed out from the outgoing night resident or night intern and then proceed to the floor and start seeing patients. So when he saw me, I had already seen patients by that point, generally, unless they were present for sign out, which they weren't generally.

I would also ask to know the specific patients that I did not see because just to give you some context, the way that we had patients, for example, there's a 60 patient census, roughly. And then there was me, another intern and then a nurse practitioner some of the time. So we divided that either two ways or three ways. And how we did it varied depending on the day -- relative demand on how we ended up splitting the list.

So I mean, it would have been impossible for me to know which patients I was going to have from one day to the next, so I'm not sure how he would have.

He went on to say that he saw Will Brook the urology resident who was working with general surgery -- they all work with general surgery their

first year -- that he saw Will most of the time. It sounds like a similar story for me. So I don't know where that differs.

And then the last point was asking him to essentially testify to the opinion of another medical student. And again, this is another instance where this is completely news to me that, one, that there was ever an accusation that I wasn't seeing patients beforehand and a medical student had claimed this. This was brought up to me in the documents after my dismissal. During my dismissal meeting with Dr. Earl and the HR representative, I was told that it was specifically for lack of integrity for this decubitus ulcer and that was it.

You know, these things keep popping up, and now, you've got Will Crews testifying the opinion of this other female medical student whose supposedly felt uncomfortable around me. You know, I would think that as a teacher, we would want to investigate that more and talk to someone rather than bring it up after I've already been fired and not say anything to anyone.

So that's about all I can say.

DR. BONDI: What time are -- what time is the transfer of care in the morning for surgical

interns?

DR. PAPIN: 6:00 a.m. sharp.

DR. BONDI: Do you come in before then and pre-round or do anything before that?

DR. PAPIN: No. That's if you -- you get sign out and then you start pre-rounding. At least that's how it works in the trauma service; other services differ.

On the trauma service, you come in at 6:00 a.m., you get signed out and then you go and see patients. And then about 6:45 a.m.-ish, you would table round with the senior resident. And then later on in the day, depending on attending preferences, you would round as a team with the attending.

DR. BONDI: Do you -- do you have to do any looking up labs or anything or X-rays during that time?

DR. PAPIN: Yes, you do.

DR. BONDI: So you --

DR. PAPIN: You would come in --

DR. BONDI: Sorry. So you see 30 patients in 45 minutes, including examining the patients and looking up their labs and X-rays?

DR. PAPIN: It was a lot. It wasn't

generally 30. That was when there was only, you know, two people in the service and that wasn't treatment, but yes, trauma was a large service, and there was a lot to get to.

DR. BONDI: Okay. Any other questions for Mr. Crews?

DR. WILLIAMS: Nilda Williams.

Can you give any specific examples of incidents where he maybe lied about anything about patients?

MR. CREWS: One frustrating event, I guess, was we were in the ER, we had a recent trauma. Dr. Sykes had just started -- one of the trauma surgeons, trauma, we were in the room. Dr. Papin sent me out, said don't worry about him. I wasn't -- you know, this was -- we had just started trauma service, so I was still kind of getting my bearings. I wasn't quite sure what was going on, and so I was, I think, waiting for the rest of the team to show up.

And then, we had another trauma come in and we started handling that. Medical students usually go grab stickers, get blankets, you know, do the things that we -- you know, we're not doctors yet, we're learning. So you do whatever -- you do

what you can.

Dr. Sykes proceeded to ask about the previous patient. Dr. Papin, I guess, wasn't quite sure, and then he proceeded to say, "Will, what happened to the patient," as if I was the one that was supposed to be keeping up with him. And obviously, you know I had no idea what was going on. And then Dr. Sykes proceeded to kind of be as lost as I was.

DR. BONDI: Okay. All right. Thank you, Mr. Crews. We appreciate your coming to see us.

MR. CREWS: Yes, sir.

(Off the record.)

DR. BONDI: Dr. Barr.

DR. BARR: I'm Rick Barr. I am the associate dean for graduate medical education and designated institution official. I'll be brief in my comments.

I met with Marc Earl, the program director of surgery. He came to me with serious concerns and wanting guidance as to next steps with Dr. Papin. He explained the details that have been described to you today, including what he concluded and I concluded, based on hearing the evidence he provided, was multiple episodes of untruthfulness,

frankly lying, that were corroborated by multiple individuals. It was not just Dr. Earl's data that he had gathered. And that some of those episodes had resulted in very serious adverse outcomes for patients. And in fact, adverse outcomes that had to be reported to CMS, such as a Stage 4 decubitus ulcer. We have to report that to the Center for Medicaid and Medicare Services, and it really affects our quality outcomes.

So we discussed -- we actively discussed whether there was -- you know, what should the step be. I -- I informed him that my recommendation would be to immediately remove Dr. Papin from any clinical service, that he should be put immediately on administrative leave with pay -- he was put on leave with pay -- until we could do a formal investigation.

My first and foremost obligation, as all of ours is in this institution, is to patients and to making -- making sure that we are following through with patient safety and optimal patient care. And in this case, until we could sort this out further, I needed to protect patients, and Dr. Papin was removed from clinical duty.

A formal investigation was -- was

performed with human resources with -- legal did not feel that this was worthy of probation with remediation -- remediation -- you know, when lying and dereliction of duty, you know, leaving the hospital when you're first call and you know, incidents such as that, I felt were profound enough that that could not be remediated. That was my advice to Dr. Earl, as well as my discussions with human resources and legal.

And the final decision was for termination, which -- which I, from the GME office standpoint, I supported.

DR. BONDI: Any questions for Dr. Barr?

I know there were some issues raised earlier about procedure as well. I think that in terms of the interrelations between the ACGME and their requirements, this would be the time to ask.

DR. HAYNES: Demondes Haynes.

Dr. Barr, I know there were a couple of issues that were brought up that Dr. Earl said he told him initially that he would be on probation, but that was purely from an academic standpoint. And it sounds like to me when HR did their investigation -- and this was brought up earlier, and I just wanted to ask you for clarification -- it

was as an employee the reason for termination so he didn't require this 60 days that Marc had initially told him about.

DR. BARR: Right. And I think that was Marc and I discussed that. I think that was Marc's perception, that any residency disciplinary action required probation with remediation. And we discussed in detail that that is for an academic issue. And your professionalism can be an academic issue, but this was clearly an employee issue. You know, lying about patient care and dereliction of duty will get any employee in this institution fired immediately. I mean, and -- and a nurse or a attending physician could be fired immediately for this type of activity. And so that -- that was an HR issue that we needed to address.

DR. BONDI: And I would just like to attempt to it put some clarity on this in terms of the policy. So from the Institutional Guidelines for Academic Remediation Office of Graduate Medical Education, University of Mississippi Medical Center, I'm reading on the second page of this document under "Conclusion," in the last two sentences. "Any behaviors which could significantly compromise patient care and/or create a hostile work

environment may be grounds for immediate action up to and including dismissal. Academic probation is always at the discretion of the program director."

Okay. I just wanted to share that with you. That is one of the -- that is one of the policies that we can talk about later, but I just wanted everyone to know that that is one of the standards that we have.

Does that -- does some of that come from the ACGME, Dr. Barr, kind of the guidelines with which we treat residents?

DR. BARR: Yes, that's some of the ACGME policies that are recommended we follow.

DR. BONDI: What other questions do anybody have for Dr. Barr?

DR. WILLIAMS: Nilda Williams.

You said that he had left campus on his first call, but it sounds like he had permission and was still on campus?

DR. PAPIN: I'm sorry. I didn't hear that question.

DR. WILLIAMS: It wasn't for you. It was just --

Dr. Barr, I'm trying to clarify what everybody's understanding is of what the running

incidents -- I mean, I can't imagine running when I'm the first call person, but anyway sounds like it's something that happens.

And does it happen, Dr. Earl?

DR. EARL: This is the first incident I've ever heard of it happening of a -- of a junior resident, even requesting to do it.

DR. BARR: Yeah. You know, whether -- whether, you know, permission was granted or not, that information was not available at the time we were discussing it. But going for a run when you're first call, I mean, to me, that -- that's professionalism in and of itself to even request that, the lack of professionalism to request that.

DR. WILLIAMS: If it was the culture of something that happened in that department, then he --

DR. EARL: It is -- I can emphatically say that it is not. I mean, anybody in -- I would say medicine in general, but certainly within surgery, it's -- that has not ever been the culture anywhere I have ever been.

DR. BONDI: Okay. Do any of the committee members have any questions for Dr. Barr before Dr. Papin has an opportunity to comment?

It's your turn, Dr. Papin. Any -- any comments on what Dr. Barr said?

MR. DILLARD: Can I make a point of clarification?

DR. BONDI: Please. Hold -- hold on one second.

MR. DILLARD: Is this our final --

DR. BONDI: No, no, no. You -- I'm going -- we'll -- what I'd like to do is let -- address all the witnesses and then Dr. Papin can have the floor to comment --

MR. DILLARD: Okay.

DR. BONDI: -- fully on the entire procedure.

MR. DILLARD: Okay.

DR. BONDI: So just specifically to what Dr. Barr discussed, do you have any comments?

DR. PAPIN: I do. In the meeting on January 10th, Dr. Earl brought up the academic remediation. He had already had a typed-up document and contract which he had me sign -- which both of us signed. And the -- he emphasized that it wasn't probation, that these were distinct deficiencies, and that probation is punitive and academic remediation is not punitive.

And that should I successfully complete this period of academic remediation, it would not be on my record and it was not cumulative in any way.

So I wanted to clarify that, the circumstances. You know, he called me into his office and told me if I didn't sign it and if I didn't submit to a drug test that I would be dismissed.

DR. BONDI: And was this the -- this was in early January?

DR. PAPIN: That's correct. January 10th.

DR. BONDI: I'm. sorry. I'm looking at -- I don't know if you have the documents in front of you, Dr. Papin, but I'm looking at the Bates Number 22 from Exhibit 2.

DR. PAPIN: 20 and 21.

DR. BONDI: Oh, I see. It's the one before that.

Okay. And if I may ask a question of Dr. Earl, what's this document? What is 22?

DR. EARL: Twenty-two is the academic remediation protocol checklist that I was given by -- that I got off of the -- the GME website or policies.

DR. BONDI: Was that ever -- was that ever

used?

DR. EARL: Was this ever used?

DR. BONDI: Yes.

DR. EARL: As far as -- no. This was something I got, I believe, that day or I was handed it that day at -- before, as I was sitting, waiting to meet with Dr. Barr on the 10th.

DR. BONDI: Okay. All right. I'm sorry, Dr. Papin. I just wanted to clarify that.

Go ahead, please.

DR. PAPIN: I don't know the document that you're referring to. I'm sorry.

DR. BONDI: It's -- well, it's -- it's -- it's entitled "Academic Remediation Protocol Checklist," and it's actually very brief, and it just has, really, dates that things occurred as opposed to the more significant document, the January 10th document, which is two pages long and has you sign. I was confused about the two documents. I wanted to make sure we were talking about the same thing.

DR. PAPIN: Certainly.

DR. BONDI: So go ahead.

DR. PAPIN: And then my final comment was if it's unprofessional to ask to go for a run --

and I also would like to say that I don't know about junior residents, but it's certainly something residents -- surgery residents in general do. But if it's unprofessional to ask, why did she grant permission?

DR. BONDI: All right. Does anybody else, including Dr. Papin, have any other questions for Dr. Barr?

All right. I -- I presume you're going to want some time to talk to him?

All right. We can take a -- a brief adjournment so that you can confer with Dr. Papin and then we'll come back and he can address the group.

(Off the record.)

DR. BONDI: Dr. Papin, are you on line?

DR. PAPIN: I am.

DR. BONDI: Okay. This is your opportunity to address any of the concerns that have been raised, to raise any other issues that you would like to. We'll let you talk and then we will ask you questions. And then Dr. Earl is going to have the opportunity once again to address the committee but not directly you, just so you know.

Go ahead.

DR. PAPIN: Okay. Dr. Earl and I signed a contract that stated that I had 60 days to demonstrate improvement. We signed it on January 10th; however, I never worked another day for this institution subsequent to that day. I was never given the opportunity to improve.

In terms of the contract itself, the academic remediation contract, what was said is that issues of untruthfulness can change the terms of the contract that he and I signed because they changed -- because now in light of new facts or what have you, Dr. Earl changed what he wanted to do to me, and that is just not -- those were not the terms of the contract.

Moreover, the only issue that was brought up to me -- and actually the only issue that was said to me in my dismissal hearing on -- in February, was that I didn't tell the truth about the state of the decubitus ulcer. That was it. Now, it becomes quite clear that -- I mean, quite clear to me that the wound care team and I both saw this wound, and we agreed that it didn't look that bad. Tragically, we were wrong, but I didn't lie.

And everything else has been brought up for the first time today. If the intent was for me

to improve on this, if the intent was for me to demonstrate improvement, it seems as if those issues would have been brought up at any time while I'm still an employee. And now it's -- we're throwing everything at the wall to see what we can hit.

So what I'd like to say is I'm dedicated to helping people. I wanted to be and still do want to be the best physician I can be. I was always asking for feedback, and if I had ever been given the chance to improve on concrete actual feedback, I would have proven to the institution that I can do this job.

DR. BONDI: Would any of committee members like to ask Dr. Papin any questions?

DR. HAYNES: Demondes Haynes.

Dr. Papin, Dr. Earl had mentioned something I wanted to ask you. You finished in Michigan, medical school?

DR. PAPIN: That's correct.

DR. HAYNES: And you applied for residency initially in urology?

DR. PAPIN: Neurosurgery, sir.

DR. HAYNES: Neurosurgery. Okay. And then, that was just the one year that you didn't match?

DR. PAPIN: That's correct.
DR. HAYNES: And then you got this spot here for general surgery?
DR. PAPIN: That's correct.
DR. HAYNES: Okay.
DR. HOUSTON: Joy Houston.
Dr. Papin, so it sounds like what happened was HR then became involved with your case. Were you not aware that HR essentially trumps anything the program director would want to do anyway?
DR. PAPIN: I -- I mean, a lot of questions in that.
DR. HOUSTON: Well, so human resources became involved. Were you not aware that human resources outranks your program director?
DR. PAPIN: No. I mean, I'm not aware of the hierarchy of the hospital administration, but Dr. Earl's own statement was that he only entered into that contract because he thought he had to, and that his real intent was to -- was dismissal.
DR. BONDI: Further questions?
Does anyone feel that they have a further question for Dr. Earl or for Dr. Barr at this time?
I'm going to let Dr. Earl if he needs to say any further comments but -- in a minute. But

any others question that the committee wants to ask?

All right. Do you have any closing comments?

DR. EARL: No. I mean, I guess I don't. I will say that during our exit interview, there was a representative from HR that was there and we were there to answer any questions. Again, the decision for termination had come from HR. And the opportunity to answer any questions or receive any information was there but Dr. Papin got up and left. And I asked him to turn in his badge, or the HR representative did, and he did not. So the opportunity to ask questions and to look at things was there, but that he did not take advantage of that.

DR. BONDI: All right. Any other comments, Mr. Dillard?

MR. DILLARD: I --

DR. PAPIN: I'd like to address that last point.

DR. BONDI: Go ahead.

DR. PAPIN: In the meeting, they -- paraphrasing what they said, you know, it's due to the lack of integrity, you lied about the sacral decubitus ulcer and it caused direct patient harm;

therefore, we're dismissing you. I asked, "Okay; is there anything else?" They said, "No." And it was at that point that I got up and left. I didn't just storm out of it at any point.

DR. BONDI: All right. That's fine.

I just want to make sure that none of the attorneys have anything they want to add to make sure we're not missing anything. Mr. Dillard?

MR. DILLARD: This is just a point of clarification, obviously. I'd love to say a lot of things --

DR. BONDI: I understand.

MR. DILLARD: -- but we have referred to and he has read some text messages. Are you intending to keep the record open for the submission of those?

DR. BONDI: I -- I don't doubt their existence. I don't know if any of the committee members have a problem with the existence of those text messages.

MR. DILLARD: Okay.

DR. BONDI: I don't have a reason to doubt them.

MR. DILLARD: Okay.

DR. BONDI: Anything else, Mr. Dillard?

Mr. Whitfield?

Mr. Ray?

MR. RAY: No.

DR. BONDI: All right. We're going to close the record and -- well, actually, don't close it yet. Sorry.

One thing is I just want to remind everyone that this committee is not going to issue a decision today. The decision is going to come in writing by me to the vice chancellor, and I just need to consult with Mr. Ray about what he wants that process to be, whether it goes to the vice chancellor first or whether it's going to be distributed contemporaneously to everybody.

So it will be quickly done. It will -- once we've met, I'll take some time to write it, review it, and I would expect it next week.

Any question or comments?

MR. RAY: Well, I'm just looking at the rules.

DR. BONDI: Okay. That's why I'm running that by the lawyers.

MR. RAY: The decision of the appeals committee will be submitted to the vice chancellor?

DR. BONDI: Correct.

MR. RAY: And the decision of the vice chancellor shall be final in accordance with bylaws of DIHL.

DR. BONDI: All right.

DR. RAY: So you submit your decision and she will take it under advisement and make her own decision.

DR. BONDI: Okay. Thank you for that clarification, Mr. Ray.

All right. We'll close the record here.

Thank you very much, Shanna. We appreciate you.

(Off the record.)

(Time Noted: 7:15 p.m.)

ORIGINAL: MARK D. RAY, ESQ.

CERTIFICATE OF COURT REPORTER

I, Shanna Cumberland, Court Reporter and Notary Public, in and for the State of Mississippi, hereby certify that the foregoing contains a true and correct transcript, as taken by me in the aforementioned matter at the time and place heretofore stated, as taken by stenotype and later reduced to typewritten form under my supervision by means of computer-aided transcription.

I further certify that under the authority vested in me by the State of Mississippi that the witness was placed under oath by me to truthfully answer all questions in the matter.

I further certify that, to the best of my knowledge, I am not in the employ of or related to any party in this matter and have no interest, monetary or otherwise, in the final outcome of this matter.

Witness my signature and seal this the 1st day of August, 2017.

Shanna Cumberland

SHANNA CUMBERLAND, CCR #1774

My Commission Expires:
April 25, 2018